



Customer Name:	Port / Account
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Authorization to The Doctors Bank to Release Account Information

I hereby authorize and direct you to release any and all information about any or all of my deposit and loan account(s) with you to Advanced Equities Wealth Management and any of its affiliates, employees, advisors, counselors, and agents (individually and collectively "Advanced Equities"). This authorization shall be in full force and effect until such time as I inform you otherwise in writing, allowing you a reasonable period of time to effect any change to the authorization.

This authorization shall apply to any and all accounts where I am an authorized signer on the account, unless I specifically direct you otherwise in writing.

This authorization shall only give Advanced Equities authorization to view my accounts, including transaction activity, balances, statements, etc. The authorization shall not allow Advanced Equities to conduct any transactions on my behalf, unless I give you such instruction in a separate writing.

I hereby indemnify you and hold you harmless for any damages, direct or indirect, which may arise as a result of this authorization.

Signature: _____

Date: _____

Print Name: _____

Social Security Number: _____

For AEWB Use Only

AEWB Financial Service ADVISOR NUMBER	_____
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